INTERPRETER FACILITATION

EVIDENCE-BASED PROTOCOL

INTERPRETER FACILITATION FOR PERSONS WITH LIMITED ENGLISH PROFICIENCY

AUTHORS
Janet Enslein, MA, RN
Toni Tripp-Reimer, PhD, RN, FAAN
Lisa Skemp Kelley, MA, RN
Eunice Choi, DNSc, RN
Laura McCarty, BSN, RN

Series Editor:
Marita G. Titler, PhD, RN, FAAN

This evidence-based practice protocol is a general guideline. Patient care continues to require individualization based on patient needs and requests.

The protocols in this series were produced with support provided by Grant #P30 NR03979, [PI: Toni Tripp-Reimer, The University of Iowa College of Nursing], National Institute of Nursing Research, NIH.

Written 4/01

Interpreter Facilitation for Persons with Limited English Proficiency

Gerontological Nursing Interventions Research Center
Research Dissemination Core (RDC)

The University of Iowa
Iowa City, Iowa

Table of Contents

			Page
Scheme for Grading the Strength and Consistency of Evidence in the Protocol			3
I.	Evidenced-based Protocol		
	A.	Background	4
	B.	Purpose	5
	C.	Definition of Key Terms	5
	D.	Indications For Use Of An Interpreter	6
	E.	Individuals at Risk for Limited English Proficiency	7
	F.	Assessment Of Limited English Proficiency	7
	G.	Description of the Practice	8
	H.	Evaluation of Process and Outcome Factors	11
		1. Process Factors	11
		2. Outcomes Factors	12
II.	Appendices		
	A.	Appendix A: Title VI of the Civil Rights Act	13
	B.	Appendix B: Languages Spoken in the United States	14
	C.	Appendix C: Methods of Interpretation	15
	D.	Appendix D: Need for Interpreter Risk Factor Assessment	16
	E.	Appendix E: Interpreter Alternatives	17
	F.	Appendix F: Interpreter Facilitation Protocol Process Evaluation Monitor	19
	G.	Appendix G: Interpreter Facilitation Provider Knowledge Assessment Test	21
	I.	Appendix H: Interpreter Facilitation Outcome Evaluation	24
	J.	Appendix I: Agency Outcomes Monitor	26

III. References 29
IV. Contact Resources 32

The University of Iowa Gerontological Nursing Interventions Research Center
Research Dissemination Core
Scheme for Strength and Consistency of Grading the Evidence in the Protocol

Evidence-based practice protocols are developed from several sources of evidence, such as research findings, case reports and expert opinion. The practice recommendations are assigned an evidence grade based upon the type and strength of evidence from research and other literature.

The grading schema used to make recommendations in this evidence-based practice protocol is:

A = Evidence from well-designed meta-analysis.

B = Evidence from well-designed controlled trials, both randomized and nonrandomized, with results that consistently support a specific action (e.g. assessment, intervention or treatment).

C = Evidence from observational studies (e.g. correlational, descriptive studies) or controlled trials with inconsistent results.

D = Evidence from expert opinion or multiple case reports.

For example, in this protocol on page 8 under the Selection of an Interpreter, a sentence is written as "Avoid using untrained interpreters because of increased distortions of the actual message due to omitting information, adding information, simplifying the message, and substituting concepts" (Macros, 1979; Vasquez & Javier, 1991, Evidence Grade = C)". This means that the practice recommendation is based upon the evidence from observational studies (e.g. correlational, descriptive studies) or controlled trials with inconsistent results.

BACKGROUND

Title VI of the Civil Rights Act of 1964 upholds the rights of persons with limited English proficiency to have equal access to or an equal opportunity to benefit from health and social services programs. The law applies to all health care institutions receiving Medicare or Medicaid funds. The Federal statute and subsequent regulations clarified in a guidance memorandum (Office of Civil Rights, 1998) specify that equal access to benefits and services requires effective communication, which may not be possible when clients are not proficient in the language of the provider. In such cases, failure to provide language assistance is a form of discrimination. Furthermore, if interpreter services are offered, the cost cannot be assigned to the client. For further information about this statute, see Appendix A.

This law affects a significant portion of residents of the United States. According to the U.S. Census Bureau (1990), 14% of the population speaks a language other than English at home, and nearly half (44%) of these people speak English less than "very well" (see Appendix B). In major cities such as Los Angeles, Miami, New York City and El Paso, more than 40% of the population speaks a language other than English at home. When these individuals attempt to receive health care from providers who do not share their language, barriers impede communication. Ideally, clients would be cared for and treated by health care providers who share clients' language and cultural background. But in reality, this is often impossible, and interpreters must be used to bridge the communication gap.

Differences in the languages spoken between clients and providers of care make clear, accurate communication impossible. These language barriers often lead to miscommunication and inappropriate treatment. Negative effects that have been attributed to disparate languages include: viewing the patient as having more severe mental health pathology, less rapport with the provider, early termination of treatment (Seijo, Gomez, & Freidenberg, 1995, Evidence Grade = C), omitted medications, missed appointments, decreased client satisfaction (Baker, Hayes, & Fortier, 1998, Evidence Grade = C), poor knowledge of the diagnosis and treatment by the client (Baker, Parker, Williams, Coates, & Pitkin, 1996, Evidence Grade = C), and decreased provider satisfaction (Kline, Acosta, Austin, & Johnson, 1980, Evidence Grade = C).

Knowledge about interpretation evolved from anthropology's concern for linguistic and cultural equivalence. Brislin (1976), and Werner and Campbell (1970) published recommendations for interpretation based upon their experiences in cross-cultural encounters. Then in the late 1970s health care literature began to appear that expressed a heightened awareness of the need for medical interpreters in health care situations. From searches of Medline and CINAHL databases, and reference lists of published materials, 56 English-language publications that pertained primarily to health care interpretation were found. Only 16 research articles were found; one was quasi-experimental (Hornberger, et al., 1996, Evidence Grade = C), and the other 15 were descriptive studies of the frequency of use of types of interpreters (Baker et al., 1996, Evidence Grade = C; Drennan, 1976, Evidence Grade = D; Hornberger Itakura, & Wilson, 1997, Evidence Grade = C); the nature of interpreters' work (Hatton, 1992, Evidence Grade = D; Hatton & Webb, 1993, Evidence Grade = D; Johnson, Noble, Matthews & Aguilar, 1999, Evidence Grade = D; Kaufert & Koolage, 1984, Evidence Grade = D; Labum, 1999, Evidence Grade = D); and

patient and provider satisfaction (Hornberger et.al, 1997, Evidence Grade = C; Kline et al., 1980, Evidence Grade = C; Kuo & Fagan, 1999, Evidence Grade = C), information recall (Seijo et al., 1995, Evidence Grade = C), and differences in patient diagnoses between interpreted and non-interpreted encounters (Dodd, 1983, Evidence Grade = C). Remaining articles repetitively described techniques for effective interpretation based upon the expert opinion of the interpreters, practitioners and researchers who authored them. The following protocol reflects the current state of knowledge which is almost entirely an Evidence Grade of D.

PURPOSE

The purpose of this evidence-based protocol is to provide information to facilitate the effective use of language interpretation services in health care settings for persons with limited English proficiency. The goals of this protocol are to increase the use of interpreters, enhance the communication process between clients and providers through effective use of interpreters, and improve the satisfaction of clients and providers in health care encounters. This protocol does not address the use of sign language interpretation for hearing impaired clients.

DEFINITION OF KEY TERMS

Interpretation

Interpretation is the processing of oral language in a manner that preserves the meaning, tone and register of the original language without adding or deleting anything. Interpretation involves a person speaking in the source language, an interpreter deciphering two linguistic codes with separate cultural and sociopolitical characteristics, and producing an equivalent message in the second language, with a third person listening to the second language version. Interpretation is a complex process. Many words or phrases do not have equivalents in other languages, and the same word may have different connotations. Consideration must be given to the register (see below) of the speaker (Brislin, 1976; Diaz-Duque, 1999).

The communication patterns are more complex in an interpreted exchange. In addition to the client-provider interaction, there are two more communication dyads, the interpreter-client interaction and the provider-interpreter interaction (Lee, 1997).

There are three basic methods of interpretation; however simultaneous and consecutive interpretation are the only methods that are appropriate for health care encounters. See Appendix C for descriptions, strengths and limitations of each method.

Translation

Translation is the processing of written language into a second language. It relates primarily to the denotative meaning of words (Brislin, 1976).

Register

Registers are levels of language that reflect differences of psychological distance between people. They are arranged on a continuum of formal-informal-intimate; the person's relative position on this continuum is affected by social role (e.g., age, gender, socioeconomic status, education level) and degree of familiarity with the participants. The register denotes important aspects of the participants' roles, so violation of the norms may limit the communication and rapport (Brislin, 1976; Diaz-Duque, 1999).

Limited English Proficiency

Limited English proficiency is the limited ability to speak, read, write or understand the English language (Office of Civil Rights, 1998).

Primary Language

Primary language is defined as the language learned as a child, and spoken in the home. It is always learned within a cultural context (Brislin, 1976).

Secondary Language

Secondary language is any language learned after the development of primary language. It may be learned without cultural knowledge (Brislin, 1976).

INDICATIONS FOR USE OF AN INTERPRETER

Clients and providers enter the health care setting with varying degrees of proficiency in secondary languages. The following criteria indicate the need for use of an interpreter in the health care exchange.

1) When the client and practitioner speak different languages (Villarruel Portillo, & Kane, 1999, Evidence Grade = D).

2) When the client has limited understanding of the practitioner's language; usually this is limited English proficiency. A basic understanding of English may not be sufficient to understand technical information, especially when the client is stressed (Villarruel et. al., 1999, Evidence Grade = D).

3) When the practitioner has only a rudimentary understanding of the client's primary language (Putsch, 1985, Evidence Grade = D)

4) When cultural tradition prohibits the client from speaking directly to the practitioner (Diaz-Duque, 1982, 1999, Evidence Grade=D).

5) At all key decision-making points in the health care process (i.e. history taking, prescribing and evaluating therapeutic procedures, before changes in treatment). This ensures informed consent and patient safety, and enables the patient to participate in planning culturally appropriate care that facilitates compliance. (Muecke, 1983, Evidence Grade = D).

INDIVIDUALS AT RISK FOR LIMITED ENGLISH PROFICIENCY

Individuals with limited English proficiency are those people who do not speak or understand any English, as well as those who demonstrate some degree of inability to understand or speak English. First generation immigrants to the U.S. are at highest risk; however that alone is not a sufficient criterion because the person may have migrated from an English-speaking nation or acquired proficiency since immigration. The following individuals may be at risk:

- First generation immigrants whose primary language is other than English.
- Second or later generation immigrants who reside in ethnic enclaves and speak a primary language other than English at home.

ASSESSMENT OF LIMITED ENGLISH PROFICIENCY (see Appendix D)

Assessment of a client's command of English is the responsibility of the health care provider. It is a process that depends upon the judgment of the provider rather than a standardized tool. The following cues may indicate a lack of understanding (Diaz-Duque, 1982, 1999; Westby, 2000, Evidence Grade = D).

- Client states that she/he speaks little or no English.
- Client requests or brings an interpreter.
- Client nods or says "yes" to all of the provider's comments and questions. This may be a culturally based demonstration of respect, or it may reflect a lack of understanding.
- Client incorrectly uses the negative case, such as when using double negatives. This is common in a secondary language.
- Client speaks a language other than English at home. This is a strong indicator of proficiency, because the language spoken at home is the language in which the person expresses emotions and has the largest vocabulary. If English is not the language used at home, the person may lack the vocabulary for self-expression, especially regarding emotional status and sensitive topics.
- Client speaks a language other than English with friends.
- Client's preferred language for reading is other than English. This may indicate the person's limited English vocabulary. However, many professionals trained in other countries read

English well because English language textbooks are frequently used for advanced education. Thus, the client may comprehend written English better than spoken English.

- Client has a brief residence in the United States. However, a long length of residence alone is not a good indicator of proficiency, because many immigrants live in communities composed of people from the same homeland and may speak only the primary language.

- Client is unable to explain or demonstrate key information. An appropriate method of assessment is for the provider to ask the client to summarize important aspects of information that the provider has told them during the encounter. Inability to repeat the information suggests a lack of understanding.

DESCRIPTION OF THE PRACTICE

Clients interviewed through interpreters are more satisfied with care received than those who receive no interpretation (Kline et al., 1980). If utilized correctly, interpreters can enhance communication among health care providers, clients and family members. Providers are responsible for establishing the framework in which the interpretation occurs. By following the guidelines below, the providers can facilitate the interpreted exchange.

Selection of an Interpreter

Selection of an appropriate interpreter is essential to accurate, open communication. Not all people can interpret with the same proficiency, thus the health care provider is responsible for selecting the best available interpreter.

Although law mandates that interpretation services be made available at no cost to clients with limited English proficiency, it is not specified how those services should be conducted nor the qualifications of the interpreters (Office of Civil Rights, 1998). Several options for interpretation exist, however choices may be limited due to cost or availability at the time.

- Use trained and professional interpreters. Trained, professional interpreters are able to provide accurate, reliable interpretations between clients and health care providers. They have a basic understanding of medical terminology, health care ethics and confidentiality, and the importance of neutrality and precision of interpretation. Use of professional interpreters produces high levels of patient and provider satisfaction (Hornberger et al., 1997; Kuo & Fagan, 1999, Evidence Grade = C)

- Try to use an interpreter of the same sex, age and social status as the client, especially if sensitive information is involved (Diaz-Duque, 1982, 1999, Evidence Grade = D).

- Avoid using untrained interpreters because of increased distortions of the actual message due to omitting information, adding information, simplifying the message, and substituting concepts (Macros, 1979; Vasquez & Javier, 1991, Evidence Grade = C).

- Avoid using family members as interpreters unless it is the client's preference. Relatives may be too emotionally involved (e.g., a husband interpreting a diagnosis of cancer to his wife), or may be suppressing information about family relationships (e.g., abusive spouses). Power differences may be created that interfere with parent-child relationships or elder-youth status. The client may be unwilling to reveal some health information (e.g. abortion or sexual history) to the family (Buchwald et al., 1993: Lee, 1997, Evidence Grade = D).

- Use of children, especially young children, as interpreters is strongly discouraged because of culturally-based barriers to discussion of certain topics across genders or age hierarchies, and lack of sufficient language proficiency in one or both languages (Haffner, 1992; Jackson, 1998. Villarruel et al., 1999, Evidence grade = D).

- Providers can advocate for development of on-staff interpreter services and access to telephone interpretation services (Villarruel et al., 1999, Evidence grade = D).

- See Appendix E for the strengths and limitations of various types of interpreters that may be available to the provider.

Before the Interpretation Session

The health care provider should allow time to prepare the interpreter before beginning the interview. This will build trust and clarify expectations.

- Identify the relationship between the client and interpreter. Knowing family relationships may give insight into power and communication dynamics. Even if they are not relatives, the interpreter may know the client because many ethnic communities are small, with everyone knowing all of the members. As a result, clients may fear that exchanges will be shared within the ethnic community. Also, the individuals' social and political status in their homeland may be barriers to honest, open communication (Buchwald et al., 1993; Chrisman & Zimmer, 2000; Lee 1997, Evidence Grade = D).

- Review the content of the session, especially sensitive topics (e.g., mental status or sexual conduct). This allows the interpreter time to ask questions, clarify terminology or express discomfort about discussing certain topics (Lee, 1997, Evidence Grade = D).

- Clarify the role of the interpreter. The provider should explain that the interpreter is to function as a voice to repeat the questions and responses of the provider and client without giving additional information, paraphrasing, or polishing with professional terminology. Unless otherwise specified, the interpreter is not expected to be a culture broker for the health care system nor the client's culture. If the interpreter perceives that a question should be modified to make it acceptable or a situation needs clarification, the interpreter should discuss it with the provider. (Villarruel et al., 1999, Evidence Grade = D).

- Explain the need for precise interpretation. The interpreter should repeat the questions and responses so as to maintain the same meaning, tone, and register as the original message. Nothing should be omitted, and nothing should be added unless it is only to explain a word/phrase that the client does not understand. The health care provider wants to know as close as possible what the client said and the emotional tone that the client's message conveys. This approach will most accurately portray the client's understanding and emotional state (Diaz-Duque, 1982, 1999; Macros, 1979, Evidence Grade = C).

- Explain that the interpreter may ask for clarification of information at any time, and may encourage the client to ask questions (Buchwald et. al., 1993; Lee, 1997, Evidence Grade = D).

During the Client Session

During the interview, the healthcare provider may facilitate effective communication by using the following guidelines (Buchwald et at. 1993; Chrisman & Zimmer, 2000; Department of Social Services, 1999; Lee, 1997, Evidence Grade = C):

- Allow sufficient time. It will take 2 to 3 times longer than a standard interview or verbal instruction.

- Ask the interpreter to sit to the side with the client and health care provider facing each other.

- Introduce yourself to the client. Then introduce yourself and the client to the interpreter.

- Follow conventions of etiquette to show respect. (e.g., stand up when the person enters, shake hands, and use titles such as Mr. and Mrs.).

- Speak to the client, not the interpreter. Address questions to the client as "you" rather than to the interpreter as "he" or "she."

- Use short, simple sentences with fewer than 16 basic words.

- Ask one question at a time.

- Use active words rather than passive voice (e.g., "I will examine your abdomen" rather than "Your abdomen needs to be examined").

- Avoid metaphors (e.g., like a maze), colloquialisms (e.g., pull yourself up by your bootstraps), and idioms (e.g., he is a brother) because such phrases are unlikely to have equivalents in the second language.

- Avoid subjunctive mood (verbs with could or would) because not all languages have a subjunctive mood.

- Reword key concepts to provide redundancy. Repetition is an effective communication method.

- Use specific rather than general terms (e.g., daily rather than frequent).

- Avoid medical terminology unless you know that the interpreter and client would be familiar with the equivalent term. It is the practitioner's responsibility to explain terminology (e.g., work up, or CT scan), not the interpreter's role.

- Use diagrams, pictures, and translated written materials to increase understanding. Prescription information and detailed instructions should be translated into the clients' language. If the client is illiterate, provide instructions in both English and the primary language because others in the support network may read for the client, or provide the instructions on audiotape or videotape.

- When speaking or listening, primarily watch the client rather than the interpreter so that non-verbal messages can be observed. This can be accomplished by having the interpreter sit next to the practitioner and across from the client.

- Be aware of non-verbal communication and verify its meaning in the client's culture.

- Be aware of your own non-verbal communication. For example, norms for direct eye contact, touch, and proximity often differ among cultures.

- Be culturally sensitive and knowledgeable, but do not stereotype. The best source of information on cultural appropriateness is the client. Conduct a cultural assessment to determine the clients' cultural beliefs. Invite correction of your understanding of information, and admit ignorance of the client's culture.

- Do not make comments that you do not want interpreted. The client may understand more than you realize.

- Do not ask the interpreter about the client's history or state of mind. The interpreter may not know the person's history and probably will not have the expertise to judge someone's mental state.

EVALUATION OF PROCESS AND OUTCOME FACTORS

To evaluate the impact of this protocol, both outcome and process factors should be evaluated.

Process Factors

A sample of healthcare providers who are using the interpreter Facilitation Protocol should be given the Process Evaluation Monitor in Appendix F. The purpose of this monitor is to assess the provider's understanding of and support for carrying out the protocol with clients.

All providers should be given the Provider Knowledge Assessment Test in Appendix G. The purpose of the test is to assess the provider's knowledge of the protocol.

Outcome Factors

To document the success of the Interpreter Facilitation Protocol, use the Outcome Evaluation Form in Appendix H. The evaluation form may be adapted to your individual agency. To determine the effectiveness for the intervention some or all of the following changes may be evaluated:

- Percentage of clients assessed for English proficiency;
- Percentage of client-provider contacts utilizing an interpreter;
- Percentage of client-provider contacts utilizing a trained interpreter;
- Percentage of clients satisfied with the care received;
- Percentage of providers comfortable with using interpreters; and
- Percentage of providers satisfied with their communications with clients who have limited English proficiency;
- Percentage of clients with "acceptable" levels of knowledge following health education instruction.

To monitor agency outcomes for Interpreter Facilitation for Persons with Limited English Proficiency, use the Agency Outcomes Monitor (See Appendix I) on a routine basis.

APPENDIX A

Title VI of the Civil Rights Act of 1964

The Civil Rights Act was enacted July 2, 1964. Title VI of the Act prohibits discrimination in, participation in, or opportunity to benefit from programs based upon a person's race, color, religion, sex or national origin. It applies to all federally assisted programs that receive Medicare or Medicaid funds either directly or indirectly through sub-grants or subcontracts (Office of Civil Rights, 1964).

Guidance Memorandum – Title VI Probation Against National Origin Discrimination – Persons with Limited English Proficiency

The office of Civil Rights of the Department of Health and Human Services issued a memorandum on January 29, 1998 to clarify standards consistent with case law and legal principles that have been developed under Title VI of the Civil Rights Act of 1964. The importance of the Guidance Memorandum is that it addresses language assistance for persons with limited English proficiency because they are at risk of being excluded from or denied equal access to services. To achieve effective communication, agencies receiving Federal funds are obligated to foster effective communication with clients with limited English proficiency. This may involve developing procedures for identifying the language needs of clients, having access to and providing interpretation services, developing procedures regarding interpreter services, and disseminating information to staff about Title VI obligations. Any interpretation services are to be provided at no cost or additional burden to the client. Compliance and enforcement are determined by the Office of Civil Rights (1998).

APPENDIX B
LANGUAGES SPOKEN IN THE UNITED STATES

There are 32 million people 5 years of age and older in the U.S. whose primary language is other than English. The table below lists the 27 most common languages spoken, with more than 100,000 speakers of each language. Of the approximately 32 million individuals who speak a language other than English, nearly 44% report speaking English less than "very well" (U.S. Bureau of the Census, 1995).

Table 1. Languages Spoken by Persons 5 Years of Age and Older in the United States

Language	Number of Speakers
English only	198,601,000
Other Than English	31,845,000
Spanish	17,339,000
French	1,702,000
German	1,547,000
Italian	1,309,000
Chinese	1,249,000
Tagalog	843,000
Polish	723,000
Korean	626,000
Vietnamese	507,000
Portuguese	430,000
Japanese	428,000
Arabic	388,000
Greek	355,000
Hindi (Urdu)	331,000
Russian	242,000
Yiddish	213,000
Thai (Laotian)	206,000
Persian	202,000
French Creole	188,000
Armenian	150,000
Navajo	149,000
Hungarian	148,000
Hebrew	144,000
Dutch	143,000
Mon-Khmer (Cambodian)	127,000
Gujarathi	102,000

(U.S. Bureau of the Census, 1995)

APPENDIX C
METHODS OF INTERPRETATION

There are 3 basic methods of interpretation; however only consecutive and simultaneous interpretation are appropriate for health care situations because these methods can preserve the detailed meanings and connotations of the messages (Diaz-Duque, 1999; Hornberger et al., 1996; Lee, 1997).

Method	Description	Strengths	Limitations
Consecutive Interpretation	The person interprets short units of speech – usually 1 or 2 sentences.	• Can provide all of the information without summarization. • Can preserve the content, register, and tone of conversation. • Promotes client rapport. • Most appropriate for dialogue. Most often used for medical interpretation.	• Slow
Simultaneous Interpretation	The interpreter sits in a special booth while listening through earphones to a speaker in another room. The interpreter simultaneously interprets into another language to which participants listen through earphones.	• Fast • Can provide all of the information without summarization. • Can preserve the content, register and tone of conversation. • Most appropriate for long speeches. • May be used for medical interpretation. • Promotes client rapport.	• Requires special equipment. • Requires a very skilled interpreter that can listen, translate and talk at the same time.
Summary Interpretation	The interpreter summarizes what each speaker says.	• Fast	• May omit important information in the condensed format. • Interpreter decides what is pertinent information, yet may not have relevant expertise. • Does not foster rapport among participants.

APPENDIX D
NEED FOR INTERPRETER
RISK FACTOR ASSESSMENT

(Goldstein, 2000)

The following questions will give the provider an indication of the client's English proficiency.

Country of Origin: _____

If U.S., Parents' country of origin: _____

Length of residence in the U. S.: _____

Age when came to the U.S. :_____

Primary Language:

- ☐ English
- ☐ _____(specify)

Client's self-report of English proficiency:

Spoken English

- ☐ Excellent
- ☐ Moderate
- ☐ Poor
- ☐ None

Written English

- ☐ Excellent
- ☐ Moderate
- ☐ Poor
- ☐ None

Understanding of Spoken English

- ☐ Excellent
- ☐ Moderate
- ☐ Poor
- ☐ None

Language spoken at home:

- ☐ English
- ☐ _____(specify)

Language spoken at work:

- ☐ English
- ☐ _____(specify)

Preferred Language with friends:

- ☐ English
- ☐ _____(specify)

Preferred language for reading:

- ☐ English
- ☐ _____(specify)
- ☐ Does not read

Preferred language to speak with health care providers: _____ (specify)

If the client does not speak English, who usually talks for the individual when English is needed? _____(specify)

If the client does not read English, who usually translates for the individual?_____

Did the client bring an interpreter?

- ☐ Yes
- ☐ No

Did the client request an interpreter?

- ☐ Yes
- ☐ No

Client behaviors:

- ☐ Nods head in response to comments and questions
- ☐ Says 'yes" in response to all questions
- ☐ Incorrectly uses the negative case
- ☐ Unable to explain or demonstrate key information
- ☐ Requests or accepts an interpreter.

APPENDIX E
Interpreter Alternatives

Interpreter Alternatives	Description	Strengths	Limitations
Professional Interpreters on staff	• Agency employs and trains interpreters who are available for interpreting languages that are most frequently represented in the particular patient population.	• Available during operating hours. • Consistent personnel fosters rapport and trust with clients and health care providers.	• Not a feasible, cost-effective alternative for small agencies. • Not all languages covered.
On-Call Interpreters	• Agency maintains a list of interpreters of various languages who are willing to interpret as need arises. • May be paid or volunteer.	• Covers a broader variety of languages.	• May have questionable interpretation abilities unless the agency has a method of testing each person. • May be trained or untrained. • Untrained interpreters make more errors: omissions of pertinent information, additions of information that the client did not say, substitutions of information, condensed summaries that omit details, and breeches of confidentiality. • Dependent upon the availability of the interpreter at the time one is needed.
Bilingual Staff	• Health care staff (nurses) or support staff (e.g., dietary aides or security personnel) are temporarily utilized as the need arises to interpret for patients with whom they would otherwise have no contact.	• Availability	• Inconsistent availability • May experience conflict of duties between the roles for which they were hired and the ad hoc interpreter duties. May create resentment in staff member or co-workers. • May be unfamiliar with specialized vocabulary. • Usually untrained. • Untrained interpreters make more errors: omissions of pertinent information, additions of information that the client did not say, substitutions of information, condensed summaries that omit details, and breeches of confidentiality. • Inconsistent ability

Interpreter Alternatives	Description	Strengths	Limitations
Family Members or Friends	• Family or friends who accompany the patient to the agency are used as interpreters	•Availability	• Untrained, thus likely to make errors (see above). • Usually unfamiliar with specialized vocabulary. • May interfere with family dynamics, confidentiality, or revelation of sensitive information. • Use of children for interpretation is never appropriate except in emergency situations until other alternatives can be arranged.
Telephone Interpretation Services	• Interpretation available over the telephone	• Covers multiple languages • Available 24 hours/day, 7 days/week • Interpreters usually have training in interpretation and may have familiarity with health care terminology •May have rapid access	• Speakerphone needed for easiest use. • Requires prior arrangement by agency to establish an account. • Interpreters may or may not be trained in mental health applications.
On-line Translation Services	• Internet web sites that translate typed statements into other languages. An example is Babylon.com	• Immediate 24 hours a day availability.	• Requires a computer with internet access. • Requires that the client be able to read, and to type responses. • Diaz-Duque (1999, Evidence Grade = D) has found them to be ineffective. Simple statements translate well; however the more complicated or ambiguous the statement, the more likely that the translation will be incorrect or incomprehensible.
Interpretation Software	• Interlingua computer software is a developing technology that will interpret conversation as it occurs. The developers at Carnegie Mellon University explain that the programs are context dependent and must be developed for specific types of situations (McCollum, 1999). May be a future alternative.	• Private • Immediate access	• Not currently available for health care applications. • Requires computer with audio input and output, and internet access.

(Carnegie Mellon University, 1999; Diaz-Duque, 1999; Haffner, 1992; Jackson, 1998; Language Line Services, 1999; Marcos, 1979; McCollum, 1999; Office of Civil Rights, 1998; Zimmermann, 1996).

APPENDIX F
INTERPRETER FACILITATION PROTOCOL
PROCESS EVALUATION MONITOR

The purpose of this monitor is to evaluate perceived understanding and support of healthcare providers to use the Interpreter Facilitation protocol.

Once staff or other persons using the protocol complete this Process Evaluation Monitor, the individual in charge of implementing the protocol needs to review the form with each person. For the ten questions, please tally the responses provided by adding up the numbers circled. For example, if Question 1 is answered "2" and Question 2 is answered "3" and Question 3 is answered "4" the nurse's score for those three questions (2+3+4) equals 9. The highest total score possible on this monitor is 40, while the lowest score possible is 10. Individuals who have higher scores on this monitor are indicating that they are well equipped to implement the protocol, and understand its use and purpose. On the other hand, those who have relatively low scores are in need of more training and/or support in the use of the protocol.

PLEASE MAKE A COPY OF THE MONITOR on the next page and ask each individual who uses the protocol to complete it approximately one month following his/her initial education and use of this protocol.

INTERPRETER FACILITATION PROTOCOL
PROCESS EVALUATION MONITOR

Directions: Please circle the number that best communicates your perception about your use of the Interpreter Facilitation Protocol.

	Strongly Disagree	Disagree	Agree	Strongly Agree
1. I feel knowledgeable to carry out the Interpreter Facilitation protocol.	1	2	3	4
2. I am able to identify clients who would benefit from the use of an interpreter.	1	2	3	4
3. I am able to carry out the activities of the interpreter intervention.	1	2	3	4
4. I feel prepared to carry out the Interpreter Facilitation protocol with the assistance of agency resources.	1	2	3	4
5. I had enough time to learn about the protocol before it was implemented.	1	2	3	4
6. I feel supported in my efforts to implement the Interpreter Facilitation protocol.	1	2	3	4
7. Implementing the Interpreter Facilitation Protocol enhances the quality of care.	1	2	3	4
8. We are managing clients with limited English proficiency better with the use of the protocol.	1	2	3	4
9. The protocol enables me to meet the health-care needs of most people with limited English proficiency.	1	2	3	4
10. The staff consistently uses the Interpretation Facilitation intervention.	1	2	3	4

APPENDIX G
INTERPRETER FACILITATION
PROVIDER KNOWLEDGE ASSESSMENT TEST

The individual who will be overseeing the use of this evidence-based protocol should be the only one with access to this test key. Following proper education of staff, with regard to this protocol, each staff who will use the *Interpreter Facilitation Intervention* should be given an opportunity to take this test. Please do not use this test as part of the nurse's typical evaluation, but instead this test should be used as a **learning tool only.** Please have each nurse take this test without the key present, and once he/she is done, let him or her code how many questions they answered correctly and incorrectly. Guidance in determining why they answered as they did can also be part of the learning process.

INTERPRETER FACILITATION
PROVIDER KNOWLEDGE ASSESSMENT KEY

1. A
2. B
3. D
4. A
5. B
6. E
7. B
8. C
9. B
10. D
11. C

INTERPRETER FACILITATION
PROVIDER KNOWLEDGE ASSESSMENT TEST

1. Interpretation differs from translation in which of the following ways?
    A. Interpretation is the conversion of spoken language into another language.
    B. Interpretation is the conversion of written language into another language.
    C. Interpretation is more accurate than translation.
    D. Interpretation is more concerned with equivalent meanings of words.

2. Approximately what percentage of the U.S. population speaks a language other than English as their primary language?
    A. 7%
    B. 14%
    C. 20%
    D. 24%

3. Persons with limited English proficiency are entitled to an interpreter because of the:
    A. Joint Commission on Accreditation of Healthcare Organizations
    B. Omnibus Reconciliation Act, 1987
    C. Patients' Bill of Rights Act, 1999
    D. Civil Rights Act, 1964

4. In health care settings, the most often used method of interpretation is:
    A. Consecutive interpretation
    B. Simultaneous interpretation
    C. Summary interpretation
    D. Medical interpretation

5. When Mrs. Gonzales arrives at the clinic the health care provider should assess her English proficiency. The most useful indicator of her English proficiency is likely:
    A. The language spoken at work
    B. The language spoken at home
    C. Her length of residence in the U.S.
    D. Her tendency to say "yes" in response to the health care provider's comments.

6. A bilingual friend and the patient's 15 year old daughter accompany a patient to the clinic for her first exam. Because the patient does not speak English, you would:
    A. Assess the friend's English proficiency and use the friend as an interpreter because she has done it many times before for other friends.
    B. Assess the daughter's English proficiency and use her as an interpreter because her English is very good.
    C. Wait a half-hour for a trained interpreter from the community to arrive.
    D. Arrange for telephone interpretation services.
    E. Ask the patient for her preference.

7. Trained interpreters should be expected to have all of the following qualifications EXCEPT:
    A. Confidentiality
    B. Culture brokerage
    C. Accuracy of interpretation
    D. Impartiality

8. Family members should not be used as interpreters because:
    A. Family members know the patients' history.
    B. Patients do not mind revealing information to family members.
    C. Patient or family members may be too embarrassed or protective to reveal some information to the provider.
    D. Using an older person as an interpreter may place them in a powerful position that could interfere with family dynamics.

9. A trained interpreter:
    A. Should give a word-for-word interpretation.
    B. Should interpret the intended meaning of the messages.
    C. Should not interpret messages that might offend the client.
    D. Should offer their opinions of the client's understanding of the information.

10. The responsibility for determining the need for use of an interpreter is the responsibility of:
    A. The interpreter or interpreter service.
    B. The patient and family.
    C. The health care agency.
    D. The health care provider.

11. When working with an interpreter, the provider should do all of the following EXCEPT:
    A. Use short, simple sentences and ask one question at a time.
    B. Repeat key ideas throughout the session.
    C. Speak to the interpreter, referring to the patient by his full name.
    D. Use pictures, diagrams and translated educational materials to enhance understanding.

APPENDIX H
INTERPRETER FACILITATION
OUTCOME EVALUATION

PLEASE MAKE A COPY OF THE FOLLOWING FORM.

The form is used to document data on the use of language interpreters for persons whose primary language is other than English. The form should be completed on the first visit and updated on subsequent visits.

INTERPRETER FACILITATION OUTCOME EVALUATION

Client name: _____

Clients' Primary Language: _____

Date client was assessed for English proficiency: _____

Client has Limited English Proficiency Yes_____ No_____

Client informed of right to interpreter services at no charge to the client Yes ____ No _____

Dates of Encounters

	Date	Date	Date	Date	Date
Interpreter Services Offered?	Yes No	Yes No	Yes No	Yes No	Yes No
Client Accepted Interpreter Services	Yes No	Yes No	Yes No	Yes No	Yes No
Who Interpreted? PI -- Professional Interpreters on staff OC – On-call Interpreter S – Staff Member F/F – Family or Friend TT – Telephone Translation Service					

APPENDIX I
AGENCY OUTCOMES MONITOR

This agency outcomes monitor should be completed on a routine basis. Either a random sample of records or all health records of clients whose primary language is other than English should be reviewed.

PLEASE MAKE A COPY OF THE MONITOR on the next page.

TO USE THE MONITOR: Place the appropriate key criteria next to the separate outcomes for each assessment. We have provided a total of 4 boxes, which represent the first four weeks of the use of this protocol. Once the chart has been completed, please make another copy of the blank form and begin numbering the new chart at Week 5.

AGENCY OUTCOMES MONITOR

Place the appropriate number next to the outcomes for each assessment period.

Criterion	Week 1 Date	Week 2 Date	Week 3 Date	Week 4 Date
Total number of clients whose primary language is other than English seen in the agency during past 7 days				
Total number of client records reviewed				
Outcome 1: Number of records that reveal that client was assessed for English proficiency				
Outcome 2: Number of clients with limited English proficiency				
Outcome 3: Number of clients informed of right to interpreter services				
Outcome 4: Number of clients offered interpreter services				
Outcome 5: Number of clients accepting interpreter of any type				
Outcome 6: Number of clients using professional interpreters on staff				

Criterion	Week 1 Date	Week 2 Date	Week 3 Date	Week 4 Date
Outcome 7: Number of clients using on-call interpreters				
Outcome 8: Number of clients using bilingual staff member to interpret				
Outcome 9: Number of clients using family or friend to interpret				
Outcome 10: Number of clients using telephone translation service				
Comments: **Week 1:** **Week 2:** **Week 3:** **Week 4:**				

REFERENCES

Key: (R)=Research (L)=Literature (N)=National Guidelines

Baker, D. W., Hayes, R., & Fortier, J. P. (1998). Interpreter use and satisfaction with interpersonal aspects of care for Spanish-speaking patients. Medical Care, 36(10), 1461-1470. (R)

Baker, D. W., Parker, R. M., Williams, M. V., Coates, W. C., & Pitkin, K. (1996). Use and effectiveness of interpreters in an emergency department. Journal of the American Medical Association, 275 (10), 783-788. (R)

Brislin, R. W. (1976). Translation: Applications and research. New York: Gardner Press. (L)

Buchwald, D., Caralis, P. V., Gany, F., Hardt, E. J., Muecke, M. A., & Putsch, R. W. (1993). The medical interview across cultures. Patient Care, April 15, 1993, 141-166. (R)

Carnegie Mellon University (1999). LTI projects [Online]. Available: http://www.lti.cs.cmu.edu/Research/Pangloss/ [1999, December, 12]. (L)

Chrisman, N.J., & Zimmer, P.A. (2000). Cultural competence in primary care. IN P.V. Meredity & N. M. Horan (Eds.), Adult primary care (pp. 65-75). Philadelphia: W. B. Saunders. (L)

Department of Social Services, The University of Iowa Hospitals and Clinics (1999). Language bank interpreter orientation manual. Iowa City, IA: McCollum. (L)

Diaz-Duque, O. F. (1982). Advice from an interpreter. American Journal of Nursing, 82(9), 1380-1382. (L)

Diaz-Duque, O. F. (1999, December 3). Interpreters in health care settings: Cultural and language issues. Presentation at University of Iowa Hospital School, Iowa City, IA.

Dodd, W. (1983). Do interpreters affect consultations? Family Practice, 1(1), 42-47. (R)

Drennan, G. (1976). Counting the cost of language services in psychiatry. South African Medical Journal, 86(4), 343-345. (R)

Goldstein, B. (2000). Cultural and linguistic diversity resource guide for speech-language pathologists. San Diego, CA; Singular Publishing Group. (L)

Haffner, L. (1992). Translation is not enough: Interpreting in a medical setting. Western Journal of Medicine, 157(3), 255-259. (L)

Hatton, D. C. (1992). Information transmission in bilingual, bicultural contexts. Journal of Community Health Nursing, 9(1), 53-59. (R)

Hatton, D. C., & Webb, T. (1993). Information transmission in bilingual, bicultural contexts: A field study of community health nurses and interpreters. Journal of Community Health Nursing, 10(3), 137-147. (R)

Hornberger, J. C., Gibson, C. D., Wood, W., Dequeldre, C., Corso, I., Palla, B., & Bloch, D. A. (1996). Eliminating language barriers for non-English-speaking patients. Medical Care, 34(8), 845-856. (R)

Hornberger, J., Itakura, H., & Wilson, S. (1997). Bridging language and cultural barriers between physicians and patients. Public Health Reports, 112(5), 410-417. (R)

Jackson, C. (1998). Medical interpretation. In S. Lour (Ed.), Handbook of immigrant health (pp. 61-79). New York, NY: Plenum Press. (L)

Johnson, M., Noble, C., Matthews, C., & Aguilar, N. (1999). Bilingual communications within the health care setting. Qualitative Health Research, 9(3), 329-343. (R)

Kaufert, J. M., & Koolage, W. W. (1984). Role conflict among culture brokers: The experience of Native Canadian medical interpreters. Social Science and Medicine, 18(3), 383-286. (R)

Kline, F., Acosta, F. X., Austin, W., & Johnson, R. G. (1980). The misunderstood Spanish-speaking patient. American Journal of Psychiatry, 137(12), 1530-1533. (R)

Kuo, D., & Fagan, M. J. (1999). Satisfaction with methods of Spanish interpretation in an ambulatory care clinic. Journal of General Internal Medicine, 14, 547-550. (R)

Labum, E. (1999). Shared brokering: The development of a nurse/interpreter partnership. Journal of Immigrant Health, 1(4), 215-222. (R)

Language Line Services. (1999). Product information [Online]. Available: http://www.language line.com/product. (L)

Lee, E. (1997). Working with Asian Americans. New York: Guilford Press. (L)

Marcos, L. R. (1979). Effects of interpreters on the evaluation of psychopathology in non-English-speaking patients. American Journal of Psychiatry, 136(2), 171-174. (R)

McCollum, K. (1999). A computer program provides 'spontaneous' translation in multiple languages. Chronicle of Higher Education, 45(49), A28. (L)

Muecke, M A. (1983). Caring for Southeast Asian refugee patients in the USA. American Journal of Public Health, 73(4), 431-438. (L)

Office of Civil Rights, U.S. Department of Transportation. (1964). Civil Rights Act of 1964 [On-line]. Available:www.dot.gov/ost/docr/civilr64. (N)

Office of Civil Rights, U.S. Department of Health and Human Services. (1998). Guidance memorandum: Title VI prohibition against national origin discrimination – Persons with limited-English proficiency [Online]. Available: http://hhs.gov/progorg/ocr/lepfinal.htm. (N)

Putsch, R. W. (1985). Cross-cultural communication. Journal of the American Medical Association, 254(23), 3344 – 3348. (L)

Siejo, R., Gomez, H., & Freidenberg, J. (1995). Language as a communication barrier in medical care for Hispanic patients. In A. M. Padilla (Ed.). Hispanic psychology: Critical issues in theory and research (pp. 169-181). Thousand Oaks, CA: Sage. (R)

U. S. Bureau of the Census. (1990). Detailed language spoken at home and ability to speak English for persons 5 years and above, United States 1990. Washington, DC: U.S. Bureau of the Census. (N)

U. S. Bureau of the Census. (1995). Statistical abstract of the United States: 1995 (115th ed.). Washington, DC: Department of Commerce. (N)

Vasquez, C., & Javier, R. A. (1991). The problem with interpreters: Communicating with Spanish-speaking patients. Hospital and Community Psychiatry, 42(2), 163 – 165. (L)

Villarruel, A. M., Portillo, C. J., & Kane, P. (1999). Communicating with limited English proficiency persons: Implications for nursing practice. Nursing Outlook, 47, 262-270. (L)

Werner, O., & Campbell, D. T. (1970). Translating: Working through interpreters and the problems of decentering. In R. Naroll & R. Cohen (Eds.), A handbook of method in cultural anthropology (pp. 398-420). New York: Columbia University Press. (L)

Westby, C.E. (2000). Multicultural issues in speech and language assessment. In J.B. Toblin, H. L. Morris, & D. C. Spriesterbach (Eds.). Diagnosis in speech-language pathology (pp. 35-62). San Diego, CA; Singular Publishing. (L)

Zimmermann, P. G. (1996). Use of interpreters in the emergency department. Journal of Emergency Nursing, 22(3), 225-227. (L)

CONTACT RESOURCES

If you have any questions regarding this protocol, please contact the authors:

Janet Enslein, MA, RN
Doctoral Student
The University of Iowa
College of Nursing
101 Nursing Building
Iowa City, Iowa 52242-1121

Lisa Skemp Kelley, MA, RN, Doctoral Candidate
Eunice Choi, Ph.D., RN, Post-Doctoral Fellow
Laura McCarty, BSN, RN
The University of Iowa
College of Nursing
Iowa City, Iowa 52242-1121

Toni Tripp-Reimer, Ph.D., RN, FAAN
Professor, Associate Dean for Nursing
Research and Director, Gerontological
Nursing Interventions Research Center
The University of Iowa
College of Nursing
Iowa City, Iowa 52242-1121

Or you may contact the series editor, Marita Titler, PhD, RN, FAAN, using the information below.

Acknowledgments

The University of Iowa Gerontological Nursing Interventions Research Center Research Dissemination Core wishes to acknowledge Juliene Lipson, PhD, RN, Professor, University of California-San Francisco, School of Nursing, and Noel J. Chrisman, PhD, Professor, University of Washington, School of Nursing, Seattle, as content expert reviewers.

This protocol is one of a number of evidence-based protocols made available by the University of Iowa Gerontological Nursing Interventions Research Center Research Dissemination Core.

For information on how to obtain additional evidence-based protocols, you may contact the Research Dissemination Core.

In Writing:
Marita Titler, PhD, RN, FAAN
Director, Research Dissemination Core
4118 Westlawn
Iowa City, Iowa 52242

By Phone:
(319) 384-4429

By FAX:
(319) 353-5843

By e-mail:
research-dissemination-core@uiowa.edu

Internet Access:
http://www.nursing.uiowa.edu/gnirc

Written 4/01